Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTH TEXAS NEUROSURGICAL CONSULTANTS, PA 800 W. ARBROOK BLVD, SUITE 150 ARLINGTON TX 76015	MFDR Tracking #: M4-03-8072-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TWIN CITY FIRE INSURANCE CO Rep Box # 47	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Enclosed please find copies of the explanation of benefits, HCFA form, external bone growth stimulator note, invoice for the unit, and **3 other carrier's EOB's showing full payment for the same code** for the above-cited date of service. We received the first reduced EOB on 4-25-03. We requested reconsideration on 5-16-03 and on 6-9-03, the carrier stilled denied any additional payment." "According to the explanation of review, code E0748 was reduced for the external bone growth stimulator stating 'reduced to fair and reasonable.' **We billed fair and reasonable according to the TWCC Medical Fee Guidelines**. To increase the chance of a successful fusion, an external bone growth stimulator was recommended for this patient. The external bone growth stimulator is both reasonable and medically necessary for treatment of this patient. We billed $4995.00 for the external unit and that is reasonable and customary according to the fee guidelines. Enclosed in the invoice for the stimulator for your review and **3 other carrier's EOB's showing payment in full for this code.**" "Also, code 20974 for the fitting for the external bone growth stimulator stating 'considered integral to the primary procedure billed.' This code is not global to the primary procedure code. We billed fair and reasonable according to the TWCC Medical Fee Guidelines. The patient had an external bone growth stimulator and had to be fitted for it which is why we billed code 20974 for the fitting. This code should not be denied as exceeding the maximum number of services for the claim. **Enclosed are 3 other insurance carrier's EOB's recommending full payment for code 20974 in the amount of $303.00 for your review**."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $2,218.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Fair & reasonable is based on what other providers' are charging not what other carriers are paying. Carrier has reduced & paid per fair & reasonable. It is providers burden of proof to show why its not fair & reasonable."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
4/4/2003	HCPCs code E0748	Not Applicable	$1915.00	$0.00
	CPT code 20974	MAR is $303.00, minus previously paid of $0.00 = $303.00	$303.00	$303.00
			Total Due:	$303.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on June 25, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 7, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 4/25/2003

   - M-Reduced to fair and reasonable.
   - F-Reimbursement is being withheld as this procedure is considered integral to the primary procedure billed.

   Explanation of benefits dated 6/9/2003

   - M-Reduced to fair and reasonable.
   - F-Reimbursement is being withheld as this procedure is considered integral to the primary procedure billed.

Issues

1. What is the applicable rule for reimbursement for HCPCs code E0748?
2. Did the requestor support the position that additional reimbursement is due for HCPCs code E0748?
3. Is the denial code supported for CPT code 20974? Is the requestor entitled to reimbursement?

Findings

1. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Division rule at 28 TAC §134.201, DURABLE MEDICAL EQUIPMENT (DME) GROUND RULE (IV), titled Nonlisted Items and Documentation of Procedure states "This document does not contain a specific MAR for the DME items. The DME items should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described."

   The requestor states in the position summary that "We billed $4995.00 for the external unit and that is reasonable and customary according to the fee guidelines. Enclosed in the invoice for the stimulator for your review and **3 other carrier's EOB's showing payment in full for this code.**"

   Division rule at 28 TAC §134.201, DME GROUND RULE (IX)(A), titled Billing states "A statement of medical necessity, along with the order or prescription appropriate for the equipment/supplies shall accompany initial claims for the rental or purchase of DME. Any verbal order given by the doctor to the DME provider shall be followed by a written prescription or order prior to billing for the DME equipment/supplies."

The requestor states in the position summary that "To increase the chance of a successful fusion, an external bone growth stimulator was recommended for this patient. The external bone growth stimulator is both reasonable and medically necessary for treatment of this patient." The requestor did not submit the order or prescription for the bone growth stimulator. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §134.201, DME Ground Rule (IX)(A).

Division rule at 28 TAC §134.201, DME GROUND RULE (IX)(B), titled Billing states "This statement shall include the medical necessity and specify the following: 1) claimant's diagnosis; 2) prognosis; and 3) the expected duration the equipment or supplies will be required." The requestor did not submit a diagnosis, prognosis or the expected duration the equipment or supplies would be required. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §134.201, DME GROUND RULE (IX)(B)(1-3).

Division rule at 28 TAC §134.201, DME GROUND RULE (IX)(C), titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline."

The provider billed HCPCs code E0748 defined as "Osteogenesis stimulator (non-invasive)." A review of the 1991 MFG does not contain a comparable "D" code for HCPCS code E0748. The requestor submitted an invoice that indicates that the unit cost $2,800.00. Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated between the provider and carrier for the disputed HCPCs code; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate for the item described per Division rule at 28 TAC §134.201 DME GROUND RULE IV.

2. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position summary states that "We billed $4995.00 for the external unit and that is reasonable and customary according to the fee guidelines. Enclosed in the invoice for the stimulator for your review and **3 other carrier's EOB's showing payment in full for this code.**"
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - In support of the requested reimbursement, the requestor submitted three redacted EOBs from three different carriers for HCPCSA code E0748. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The reimbursement methodology is not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample EOBs, was typical for the services in dispute.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

   The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for HCPCS code E0748. Additional payment cannot be recommended.

3. CPT code 20974 is described as "Electrical stimulation to aid bone healing; noninvasive (nonoperative)." Per Division rule at 28 TAC §134.201, the MAR for CPT code 20974 is $303.00. The respondent denied reimbursement based upon this service being integral to the primary procedure billed. Division rule at 28 TAC §134.201, SURGERY GROUND RULE (D)(2), titled Multiple Procedures states "Procedures that are performed only as additions to other procedures are already reduced accordingly in the fee guideline and shall not be further reduced as per the Multiple Procedure Rule. The following codes shall not be reduced by the Multiple Procedure Rule: 20974." The requestor submitted a chart note that states "Patient is status post cervical fusion. Patient in today for application and instruction of SpinaLogic external bone growth stimulator." Therefore the denial reason code is not supported and reimbursement of $303.00 is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor for CPT code 20974. For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $303.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $303.00 additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $303.00 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**July 7, 2010** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.